Submit Claims to:
Flexible Benefits Account Administrator
P.O. Box 1080
Denver, CO 80201

(303) 689-3649 (In Colorado)
(800) 759-4952 (Outside Colorado)
Automated phone system available 24 hours a day

Flexible Benefits Account Reimbursement Request

Instructions:
1. Fill in the employee information and *Part A* and/or *Part B* completely.
2. Have day care provider sign below OR attach receipts for expenses incured for *Part A.*
3. Attach copy of Explanation of Benefits (EOBs) for expenses covered by health insurance OR attach itemized bills from your provider(s) for expenses not covered by medical/dental insurance far *Part B.*
4. Keep *a* copy of all submitted expenses.
5. Submit Health Care claims monthly.

Employee Information *(must be completed in full)*

Employer name: _____ Plan #: 50703

Employee's name: _____ Social Security #: _____

Home address: _____ Address change? Yes ☐ No ☐

City/State/Zip: _____

Part A. DEPENDENT CARE & DAY CARE EXPENSE INFORMATION *(all information MUST be filled out completely)*

Name of day care provider _____ Address: _____

Tax ID number _____ OR Social Security number: _____ **(Information MUST be filled in)**

Dependent name(s)	Date of birth mm/dd/yy	Relationship to insured	Are you entitled to an income tax exemption for this dependent?	Dates of service mm/dd/yy to mm/dd/yy	Total charges
1.	/ /		☐ Yes ☐ No	/ / to / /	$
2.	/ /		☐ Yes ☐ No	/ / to / /	$
3.	/ /		☐ Yes ☐ No	/ / to / /	$

RECEIPTS ARE NOT NECESSARY IF DEPENDENT CARE PROVIDER SIGNS THIS SECTION.
I certify above charges have been incurred: Signature of Dependent Care Provider _____ Date _____

I certify that dependent care expenses were incurred to allow myself and/or my spouse to be employed outside the home. I understand that dependent care expenses reimbursed from the Dependent Care Account cannot be claimed as a Child Care Tax Credit on my Federal Income Tax Return.

Employee signature (required) _____ Date _____

Part B. HEALTH CARE EXPENSE INFORMATION *(all information MUST be filled out completely)*

Amount of reimbursement requested: $ _____ (This amount does not include any expenses covered by insurance.)

EMPLOYEE CERTIFICATIONS *(MUST check one)*

☐ I am covered under an insurance plan for these expenses. My explanation of benefits (EOBs) are enclosed. The attached receipts and/or EOBs total the amount I have requested.
☐ I have no insurance coverage for the attached expense(s).

I certify that the attached charges are eligible health care expenses under the Internal Revenue Code (IRS) and that these charges have been incurred and I have not been reimbursed by any other source for these charges. I also certify that they will not be claimed as a deduction on my personal income tax.

SIGNATURE IS REQUIRED. UNSIGNED FORMS WILL BE RETURNED.

Employee signature (required) _____ Date _____